STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

IN RE: Genesis Health Ventures of Bloomfield, Inc. of Kennett Square, PA d/b/a Kimberly Hall North
1 Emerson Drive
Windsor, CT 06095

CONSENT ORDER

WHEREAS, Genesis Health Ventures of Bloomfield, Inc. of Kennett Square, PA d/b/a Kimberly Hall North (hereinafter the "Licensee"), has been issued License No. 1076C to operate a Chronic and Convalescent Nursing Home known as Kimberly Hall North, (hereinafter the "Facility") under Connecticut General Statutes Section 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the "Department"); and

WHEREAS, the Facility Licensing and Investigations Section (hereinafter the "FLIS") of the Department conducted unannounced inspections on various dates commencing on December 16, 2008 and concluding on January 2, 2009; and

WHEREAS, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in a violation letter dated February 3, 2009 (Exhibit A – copy attached); and

WHEREAS, a conference regarding the February 3, 2009 violation letter was held between the Department and the Licensee on April 14, 2009 and May 27, 2009; and

WHEREAS, the Licensee is willing to enter into this Consent Order and agrees to the conditions set forth herein.

NOW THEREFORE, the FLIS of the Department acting herein and through Barbara Cass, Public Health Services Manager, and the Licensee, acting herein and through Robert Reitz, its Executive Vice President/Chief Operating Officer hereby stipulate and agree as follows:

1. The facility shall execute a contract with a Wound Physician approved by the Department within two (2) weeks of the effective date of this consent order. The

Wound Physician shall serve a minimum of eight (8) hours a week for a six (6) month period and shall conduct training, provide oversight to nursing staff, maintain weekly statistics, observe all pressure sores, monitor preventative protocols and assess patients at risk for pressure sores or vascular sores.

2. The Facility shall execute a contract with a credentialed Wound Care RN approved by the Department within two (2) weeks of the effective date of this consent order. The credentialed Wound Care RN shall serve a minimum of twelve (12) hours a week for a six (6) month period and shall conduct training, provide oversight to nursing staff, maintain weekly statistics, observe all pressure sores, monitor preventative protocols and assess patients at risk for pressure sores or vascular sores.
3. The Wound Physician and the credentialed Wound Care RN shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well-being of the patients and to secure compliance with applicable federal and state law and shall not accept any direction or suggestion from the Licensee or its employees that will deter or interfere in fulfilling this obligation.
4. The credentialed Wound Care RN contracted to provide wound care oversight shall provide a bi-weekly report to the Department regarding his/her responsibilities and an assessment of the Facility's progress as related to issues of skin integrity.
5. Copies of all Wound Care RN reports shall be simultaneously provided to the Director of Nurses, Administrator, Medical Director and the Department.
6. The Wound Physician and the Wound Care RN shall have the responsibility for:
    a. Assessing, monitoring, and evaluating the delivery of wound and/or skin care by registered nurses, licensed practical nurses, nurse aides, and orderlies and implementing prompt training and/or remediation in any area in which a staff member demonstrated a deficit. Records of said training and/or remediation shall be maintained by the Licensee for review by the Department;
    b. Assessing, monitoring, and evaluating the coordination of wound and/or skin services delivered by the various health care professionals providing services;
    c. Recommending to the Department an increase in the Wound Care RN's contract hours if the Wound Care RN is unable to fulfill the responsibilities within the stipulated hours per week; and

d. Monitoring the continued implementation of the Licensee's plan of correction as it relates to wound and/or skin care submitted in response to the violation letter dated February 3, 2009 (Exhibit A).

7. The Wound Care RN, the Licensee's Administrator, and the Director of Nursing Services shall meet with the Department every six (6) weeks for the first three (3) months after the effective date of this Consent Order and thereafter at eight (8) week intervals throughout the tenure of the Wound Care RN. The meetings shall include discussions of issues related to the care and services provided by the Licensee and the Licensee's compliance with applicable federal and state statutes and regulations.
8. Any records maintained in accordance with any state or federal law or regulation or as required by this Consent Order shall be made available to the Wound Physician, Wound Care RN and the Department, upon request.
9. The Department shall retain the authority to extend the period of the credentialed Wound Care RN functions are required, should the Department determine that the Facility is not able to maintain substantial compliance with federal and state laws and regulations pertinent to pressure ulcers. Examples of violations which may cause the Department to invoke this provision include, but are not limited to, failure to notify the physician of a significant change in skin condition, and/or failure to provide care and treatment to patients identified with skin integrity issues and/or failure to implement physician orders. Determination of compliance with federal and state laws and regulations will be based upon findings generated as a result of onsite inspections conducted by the Department.
10. Within fourteen (14) days of the execution of this Consent Order the Director of Nurses shall develop and/or review and revise, as necessary, policies and procedures related to physical assessment of patients with pressure ulcers, pressure ulcer prevention and treatment, documentation and tracking of pressure ulcers, care planning, interventions pertinent to pressure ulcers, and turning and repositioning of patients.
11. Within twenty-one (21) days of the effect of the Consent Order all Facility nursing staff shall be inserviced, to the policies and procedures identified in paragraph number ten (10).
12. The Facility's medical staff shall review all policies and procedures related to skin integrity and shall document their examinations of all patients relative to impaired skin integrity.

13. Effective upon the execution of this Consent Order, the Licensee, through its Governing Body, Administrator and Director of Nursing Services, shall ensure substantial compliance with the following:
    a. Sufficient nursing personnel are available to meet the needs of the patients;
    b. Patient treatments, therapies and medications are administered as prescribed by the physician and in accordance with each patient's comprehensive care plan;
    c. Patient assessments are performed in a timely manner and accurately reflect the condition of the patient;
    d. Each patient care plan is reviewed and revised to reflect the individual patient's problems, needs and goals, based upon the patient assessment and in accordance with applicable federal and state laws and regulations;
    e. Nurse aide assignments accurately reflect patient needs;
    f. Each patient's nutritional and hydration needs are assessed and monitored in accordance with his/her individual needs and plan of care;
    g. The personal physician or covering physician is notified in a timely manner of any significant changes in patient condition including, but not limited to, decline in skin integrity, presence of any infection, and deterioration of mental, physical, nutritional, and/or hydration status. In the event that the personal physician does not adequately respond to the patient's needs or if the patient requires immediate care, the Medical Director is notified;
    h. Patient's with pressure sores and/or impaired skin integrity are provided with the necessary care to treat and prevent pressure sores and/or impaired skin integrity. Wounds, including pressure sores, are monitored and assessed in accordance with current regulations and standards of practice;
    i. Necessary supervision and assistive devices are provided to prevent accidents;
    j. Policies and procedures related to dehydration prevention will be reviewed and revised to include, in part, notification of the attending physician or medical director when the patient's fluid intake does not meet their assessed needs; and
    k. Patient injuries of unknown origin are thoroughly investigated, tracked, and monitored.
14. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the Facility to monitor the requirements of this Consent Order.

The name of the designated individual shall be provided to the Department within said timeframe.

15. The Licensee shall pay a monetary penalty to the Department in the amount of two thousand dollars ($2,000.00), by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department within (2) weeks of the effective date of this Consent Order. The money penalty and any reports required by this document shall be directed to:

    Lori-Ann Griffin, R.N., Supervising Nurse Consultant
    Facility Licensing and Investigations Section
    Department of Public Health
    410 Capitol Avenue, P.O. Box 340308 MS #12HSR
    Hartford, CT 06134-0308

16. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Order or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, including all options for the issuance of citations, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.
17. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
18. The terms of this Consent Order shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.
19. The Licensee understands that this Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not

deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.

20. Should the Licensee not be able to maintain substantial compliance with the requirements of the Consent Order the Department retains the right to issue charges including those identified in the February 3, 2009, violation letter referenced in this document.
21. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Order.

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WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below.

Genesis Health Ventures of Bloomfield, Inc. of Kennett Square, PA – Licensee

7/30/09
Date

By: _____
Robert Reitz, its Executive Vice President/Chief Operating Officer

STATE OF Pennsylvania)

County of Chester) ss July 30th, 2009

Personally appeared the above named Robert A. Reitz and made oath to the truth of the statements contained herein.

My Commission Expires: 10/14/12
(If Notary Public)

Anne Marie Lysle
Notary Public [✓]
Justice of the Peace [ ]
Town Clerk [ ]
Commissioner of the Superior Court [ ]

COMMONWEALTH OF PENNSYLVANIA
Notarial Seal
Anne Marie Lysle, Notary Public
New London Twp., Chester County
My Commission Expires Oct. 14, 2012
Member, Pennsylvania Association of Notaries

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

8/6/09
Date

By: Wendy H. Furniss, RNC, M.S.
~~Barbara S. Cass, Public Health Services Manager~~
~~Facility Licensing and Investigations Section~~

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 16

February 3, 2009

Mr. Thomas Russo, Administrator
Kimberly Hall North
1 Emerson Drive
Windsor, CT 06095

Dear Mr. Russo:

Unannounced visits were made to Kimberly Hall North commencing on December 16, 2008 and concluding on January 2, 2009 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a certification inspection.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by February 14, 2009 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).

2. Date corrective measure will be effected.

3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Angela White RN (BSN)

Angela B. White, R.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

ABW:lsl

c. Director of Nurses
Medical Director
President

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

EXHIBIT A

DATES OF VISIT: commencing on December 16, 2008 and concluding January 2, 2009

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2)(L) and/or (k) Nurse Supervisor (1).

1. Based on clinical record review, observation and staff interview for two of seven sampled residents (Resident #30, #162) who were reviewed for pressure ulcers and/or diabetic monitoring, the facility failed to ensure that the physician was promptly notified when a change in treatment was needed or a significant change was noted. The findings included:
    a. Resident #30 had an assessment dated 9/9/08 that indicated long and short- term memory deficit, resistive to care, required extensive assistance with Activities of Daily Living and abnormal laboratory values within the last ninety days. Review of laboratory results dated 11/17/08 identified R #30's Potassium level was 5.8 (normal level: 3.5-5.5). Physician order dated 11/18/08 directed in part, Kayexalate 30 grams to be given by mouth daily for two days. Review of the Medication Administration Record (MAR) dated 11/18/08 at 9 AM noted the medication was not available. A nurse ' s narrative note dated 11/18/08 at 3PM noted the lab value dated 11/17/08 of R #30 ' s Potassium was elevated to 5.8,with an order noted. Further review of a nurse ' s note dated 11/19/08 reflected a call was placed to the physician secondary to increased potassium level. Interview with LPN #1 on 12/22/08 at 11AM revealed the medication was not available on 11/18/08. She also stated that she did not notify the physician on 11/18/08 that the medication was not available.
    b. Resident #162 was admitted to the facility on 8/20/08 with diagnoses that included insulin dependent diabetes. An assessment dated 9/5/08 indicated long and short term memory impairment, resistance to care and required extensive assistance with Activities of Daily Living. A plan of care initiated 9/15/08 reflected R #162 had a diagnosis of insulin dependent diabetes. The interventions included blood sugar monitoring by fingerstick. Also, staff to monitor for sign and symptoms of hypo/hyperglycemia and to notify the physician of glucose less than 60. Review of the clinical record indentified nurse's narrative notes and/or documentation from the Medication Administration Record (MAR) dated 10/1/08 through 10/5/08 and 10/7/08 indicated the resident's blood sugar via fingerstick was between 43 through 69. The notes also indicated the resident was served orange juice due to low blood sugar. Review of the facility's Diabetic Care Protocol directed in part, to notify the physician immediately if blood glucose is greater than 400 or less than 70. The protocol also directed staff to the Hypoglycemia Protocol. Review of the Hypoglycemia Protocol directed in part, if fingerstick was below 70 to repeat the juice and fingerstick. If no improvement, notify the physician. Review of the clinical record with the Director of Nursing on 12/23/08 at 12PM failed to provide evidence the physician was notified of the resident's low blood sugar. The Director of Nursing stated that the expectation of licensed staff was to notify the physician when the glucose was less than 70.

EXHIBIT A

DATES OF VISIT: commencing on December 16, 2008 and concluding January 2, 2009

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1).

2. Based on observation and staff interview for three sampled residents (Resident #7, #133, #39) who were observed during dining and/or personal care, the facility failed to ensure dignified care was provided. The findings included:
   a. Resident #7 had diagnoses that included dementia with delusions. An assessment dated 5/21/08 indicated long and short-term memory impairment, moderately impaired cognition, and required extensive assistance with eating. Observation on 12/16/08 at 12:20PM during the noon meal identified R #7 shared a table with two other residents. The residents were served at 12:20 PM and were assisted with their meals. Resident's #7 tray was removed from the meal cart at 12:50PM, 30 minutes later, at which time the resident was fed. Interview with RN #5 on 12/23/08 indicated she had walked into the dining room and noticed that the resident was not fed.
   b. Resident #133 had an assessment dated 8/14/08 that indicated long and short term memory impairment, moderately impaired cognition, required limited to extensive assistance with Activities of Daily living and independent with meals. A plan of care dated 8/27/08 identified R #133 exhibits or was at risk for impaired swallowing. Interventions included supervision during meals. Observation on 12/16/08 during the noon meal noted R #133 shared a table with another resident. Resident #133's table mate was served the meal at 12:20 PM, completed the meal and exited the dining room. Observation on 12/16/08 at 12:20 PM indicated a tray on the table, (Resident#133's tray) covered with a clothing protector. Further observation indicated #133 was served the tray at 12:50 PM, 30 minutes later, at that time R #133 asked where the other resident was. Nurse Aide #4 replied that the other resident had already eaten and left the dining room. Interview with Nurse Aide #5 on 12/19/08 at 12:40 PM indicated R #133's meal was on the cart, however staff was unaware and failed to serve the meal.
   c. Resident #139 had diagnoses that included memory loss and dementia. An assessment dated 12/3/08 indicated long and short- term memory impairment, and required total assistance with Activities of Daily Living. A plan of care dated 12/16/09 identified R #139 was at risk for impaired swallowing related to dementia. The interventions included direct supervision during meals. Observation on 12/16/08 at 12:20 indicated R #139 was seated at a table in the dining room with four other residents. The three residents were served their meal and were being assisted and/or being fed. R #139's meal was served at 12:50 PM. Interview with NA #5 on 12/16/08 at 1PM indicated nurse aides were not allowed to feed two residents at the same time. The interview further indicated that there were many residents to be fed in the dining room and she believed there was not enough help. Interview with the Administrator on 12/23/08 at 10 AM indicated the facility had an "all hands on deck" policy and everyone must assist residents in the dining room. The interview further indicated that the expectation was

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

not to have residents being fed while others watch them eat.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1).

3. Based on clinical record review, observation and staff interview for two of six residents (Resident #14, #162) who were reviewed for pressure ulcer care, the facility failed to complete accurate assessments. The findings included:
    a. Resident #14 had an assessment dated 11/20/08 that indicated long and short- term memory impairment, required total assistance with Activities of Daily living, functional limitations of the leg and/or foot and a Stage IV pressure ulcer. A Skin Integrity Report dated 12/5/08 indicated measurement of a wound on the left heel to be 4 cm X 7.6 cm. R #14 was discharged from the facility to an acute care facility on 12/8/08. R #14 was readmitted to the facility on 12/18/08. The acute care documentation dated 12/18/08 indicated R #14 underwent left heel incision and debridement(I and D). Review of the nursing readmission assessment dated 12/18/08 which was conducted by LPN #5 indicated an open area to the left heel that measured 10 cm x 8cm. Review of the skin integrity report dated 12/18/08 with RN#1identified the left heel to have a slight odor and measured 7cmX4.5cmX2cm.
    b. Resident #162 was admitted to the facility on 8/20/08 with diagnoses that included insulin dependent diabetes. An assessment dated 9/5/08 indicated long and short term memory impairment, resistance to care and required extensive assistance with Activities of Daily Living. A plan of care initiated 9/15/08 reflected R #162 had a diagnosis of insulin dependent diabetes. The interventions included blood sugar monitoring by fingerstick. Also, staff to monitor for sign and symptoms of hypo/hyperglycemia and to notify the physician of glucose less than 60. Review of the clinical record indentified nurse's narrative notes and/ or documentation from the Medication Administration Record (MAR) dated 10/1/08 through 10/5/08 and 10/7/08 for the 6:30 AM blood sugar monitoring indicated the resident's blood sugar via fingerstick was between 43 through 69. The notes also indicated the resident was served orange juice due to low blood sugar. Review of the facility's Hypoglycemia Protocol directed in part, to assess the resident's condition. Interview with the Director of Nursing on 12/23/08 at 12PM she stated that the expectation of licensed staff is to assess a resident after a hypoglycemic episode as per the policy.

EXHIBIT A

DATES OF VISIT: commencing on December 16, 2008 and concluding January 2, 2009

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (o) Medical Records (2)(I).

4. Based on clinical record review, observation and staff interview for one of ten residents (Resident #19) who were reviewed for pressure ulcer care, the facility failed to revise the care plan when needed and/or invite the responsible party to the care conferences. The findings included:
   a. R#19 was readmitted to the facility on 11/7/07 with diagnoses that included insulin dependent diabetes. The readmission assessment dated 11/7/07 identified R #19 ' s buttocks were macerated, however intact. An assessment dated 10/22/08 indicated long and short- term memory impairment, moderated impaired cognition, required extensive assistance with Activities of Daily Living, two Stage III pressure ulcers and one Stage IV pressure ulcer.
   Observations on 12/19/08 revealed R #19 ' s left ear had reopened. The area measured 1.5X1.0CM. Constant observations on 12/22/08 from 6:55AM through 9:46 AM identified R #19 to be positioned on the back with ears touching a pillow. Interview with the ICN on 12/22/08 at 9:50 AM indicated the resident was not to be positioned on a pillow unless upright in bed during meals. She further stated the resident had a history of pressure areas on the ears and must not use a pillow while in bed. Review of the plan of care with the infection control nurse on 12/23/08 at 10 AM failed to provide evidence the plan of care was reviewed and or/revised to reflect such.

   Interview with Person #1 on 12/17/08 at 12:20 PM identified that he was not invited to the quarterly care plan meetings. Review of the clinical record reflected that the quarterly care plan meetings dated 2/28/08; 5/22/08; 8/14/08 and 11/5/08 indicated family member/resident was invited but did not attend. A social service note dated 11/10/08 indicated the conservator was notified but did not attend. Interview RN #2 on 12/18/08 at 9:50 Am identified she sent a list of residents who were due for care plan to the receptionist monthly. Interview with the Receptionist on 12/18/08 at 10:00 AM identified a copy of the letter sent to the responsible party was sent to the Social Worker. Interview with Social Worker on 12/18/08 at 10:20 Am indicated she did not keep a copy of the sent to the responsible party. Although the facility indicated the responsible party was notified of the quarterly care plan meetings, they were unable to provide evidence of such notifications.

EXHIBIT A

DATES OF VISIT: commencing on December 16, 2008 and concluding January 2, 2009

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A).

5. Based on clinical record review, observation, review of facility policies and staff interview for two sampled residents (Resident #13, #72) with specific care needs, the facility failed to ensure that care was provided according to professional standards of practice. The findings include:
   a. R # 13's diagnoses included neuropathic pain. The MDS dated 12/4/08 identified modified independence in decision making skills, and moderate daily pain. The resident care plan dated 10/2/08 identified alteration in comfort related to osteoarthritis and neuropathic pain. Interventions included to medicate the resident as ordered for pain. Observation during the medication pass on 12/16/08 at 10:10AM identified LPN #1 opened the medication cart and took out a cup containing 4 pills. Observation of the cup identified the cup was not labeled. Interview at that time with LPN #1 stated that the medications were for R #13 and that they were a multivitamin, Tylenol, Aspirin, and Tramadol. Additionally, LPN #1 was observed to put 13 more medications in the pill cup. The nurse was observed to administer the medications to the resident. Interview with LPN #1 at 10:20AM stated that she poured the 4 pills earlier for R #13 but she was sleeping so she put the medications in the cart. Review of the medication order sheets dated 11/18/08 identified APAP (Tylenol) 1000mg to be administered at 7AM. Additionally, the orders identified to administer Tramadol HCL 50mg at 7AM. Interview with the Director of Nursing on 12/18/08 stated that medications are to be stored in the medication cart; they should not be poured until they are going to be administered. According to Basic Nursing, Mosby, Third Edition, the five guidelines to ensure safe drug administration include the right drug, the right dose, the right client, the right route and the right time.
   b. Resident #72's diagnosis included Alzheimer's dementia and severe COPD. The MDS dated 10/6/08 identified short and long-term memory problems and moderately impaired cognition. The care plan dated 10/10/08 identified the resident was oxygen dependent with a goal that there be no respiratory distress. Interventions included, in part, to observe respiratory status and to provide oxygen as per the physician order. Physician order dated 10/31/08 directed to administer oxygen at two liters via a nasal canula continuously.

      Observation on 12/16/08 at 1:00PM identified the resident was seated in the dining room with the nasal canula in place which was attached to the portable oxygen canister and a round device was noted at chest level as part of the tubing, (an Oxymizer). Additionally, interview and review of the oxygen tank gauge with RN#1 on 12/16/08 at 1:00PM identified the gauge read "refill " Furthermore, RN#1 took out an oxygen key, turned a device on the top of the portable tank and the dial went up. Subsequently, the gauge no longer read, "refill" and it showed the oxygen level. Interview with RN #4 on 12/16/08

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

at 1:10PM identified that a similar situation happened with another resident who required oxygen. The gauge read, "refill" and when RN #4 used the oxygen key to move the device on the top of the portable oxygen canister, it no longer read "refill" and it showed the oxygen level. Additionally, RN#4 stated that she did not report this incident. Interview with the Oxygen Representative on 12/18/08 at 10:15AM identified that if the oxygen gauge reads "refill," oxygen is not flowing through the tubing to the resident. Additionally, the Oxygen Representative stated that he was not made aware of any problem with the oxygen gauges. According to the Nurse Practice Act Section 20-87a, definition of nursing, the practice of nursing by a registered nurse is defined as the process of diagnosing human responses to actual or potential health problems, providing supportive and restorative care, health counseling and teaching, case finding and referral, collaboration in the implementation of the total health care regime and executing the medical regimen under the direction a licensed physician.

Review of the clinical record failed to show that a physician order was in place for the use of the oxymizer. Additionally, review of the 12/2008 treatment kardex identified there was no documentation of the Oxymizer having been implemented and/or utilized for Resident #72. Interview with LPN#2 on 12/16/08 at 1:10PM identified that although Resident #72 has utilized the Oxymizer for a long while, no physician order or documentation could be found addressing the Oximizer. Additionally, LPN#2 stated that the Oximizer converts 0.5 liters of oxygen into 2 liters; therefore, the setting for the resident ' s oxygen should be set for 0.5 liters. Review of the facility policy on the Oxymizer directs, in part, that oxygen therapy via the Oxymizer is administered as ordered by a physician and includes correct flow rate, mode of delivery and frequency. Additionally, the policy directs that oxygen is set up and monitored by a licensed nurse or respiratory therapist. According to Photo Guide of Nursing Skills, Smith, Duell & Martin, 2002, Oxygen is considered a drug that requires a physician ' s prescription for administration (p.694).

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A).

6. Based on clinical record review, observation and staff interview for one sampled resident (Resident #176) observed during a meal, the facility failed to ensure that the plan of care was followed regarding cueing during the meal. The findings include:
    a. Resident #176 was admitted to the facility on 12/11/08 with diagnoses that included kyphosis and sclerosis. Initial physical therapy assessment from 12/8/08 to 12/11/08 indicated sitting balance to be impaired as evidenced by difficulty when unsupported. Observations on 12/16/08 and 12/17/08 during the lunch meal noted R #176 to be leaning towards the left without redirection to reposition; there was some food spillage

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

on the clothing protector. Interview with RN #1 on 12/18/08 at 12:20 PM identified that the resident had the ability to reposition upon direction. Interview with the Physical Therapist on 12/18/08 at 1PM noted R #176 was independent with repositioning upon cueing. The interview also indicated the expectation is for staff to cue the resident regarding repositioning.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A).

7. Based on clinical record review, observation and staff interview for three sampled residents (Resident #'s 127, 139 and 178) observed during a meal and/or incontinent care, the facility failed to provide the necessary care and services during the meal and/or provide incontinent in an appropriate manner. The findings include:
   a. R# 127's diagnoses include Alzheimer ' s disease, behavioral disturbances, and psychosis. The MDS dated 9/25/08 identified severe cognitive impairment, and total staff assistance for eating. The resident care plan dated 10/14/08 identified requires assistance for ADLs and at risk for impaired swallowing. Interventions include provide diet as ordered, and provide supervision and assistance with meals. Observation on 12/16/08 at 9:45AM identified the dining truck on the unit with resident ' s trays still in it. Interview at that time with NA# 1stated that R # 127 had not been fed as of yet and that the breakfast trays come to the floor between 7:30AM and 7:45AM. Observation at 9:55AM identified RN #1 go to the food cart and remove R #127's tray, RN#1 was observed to go into the resident's room with the tray and exit it right after with the tray. RN #1 then walked down the hall, starting talking to R # 127 who was returning from therapy and turn around and proceed back to R #127's room with the meal tray. The resident was observed entering into the room. At 10AM RN#1 was observed feeding the resident in the room. Interview with RN# 1 at 1PM on 12/16/08 identified that she saw the resident's tray on the cart and went to feed her; she further stated that she was unsure of the time. Additionally, RN#1 stated that she should have heated it up or called the kitchen for a new tray.
   b. Resident #139 had diagnoses that included memory loss and dementia. An assessment dated 12/3/08 indicated long and short- term memory impairment, required total assistance with Activities of Daily Living. A plan of care dated 12/16/09 identified R #139 was at risk for impaired swallowing related to dementia. The interventions included direct supervision during meals. Observation on 12/16/08 at 12:20 indicated R #139 was seated at a table in the dining room with four other residents. The three residents were served their meal and were being assisted and/or being fed. R #139 meal was served at 12:50 PM. Interview with NA #5 on 12/16/08 at 1PM indicated nurse aides were not allowed to feed two residents at the same time. The interview further indicated that there were many residents to be fed in the dining room and she believed

there was not enough help. Interview with the Administrator on 12/23/08 at 10 AM indicated the facility had an all hands on deck policy and everyone must assist residents in the dining room. The interview further indicated that the expectation was not to have residents being fed while others watch them eat.

c. Resident #178's diagnoses included Alzheimer's disease. An assessment dated 12/13/08 identified impaired cognition, limited assistance for bed mobility and bladder incontinence. The care plan dated 12/23/08 identified incontinence with interventions that included providing perineal and incontinent care as needed. Observation on 1/2/09 at 10:35 AM identified the resident supine in bed. Nurse Aide #5 held a towel that was wet on one end with water in her hand and began to provide incontinent care to the resident. The resident's legs were closed and NA #5 attempted to pry the legs open to provide care. Although NA #5 was unable to open the legs, NA #5 continued to swipe the towel through the closed legs to provide care. The resident was noted to moan during NA #5's attempt to wash the resident. Upon surveyor intervention, NA #5 stopped care. Interview with NA #5 at the time indicated she was using a towel to wash the resident because there were no washcloths available on the unit. Interview with the Staff Development Nurse on 1/2/09 at 10:45 AM identified the facility had disposable Aloe cleansing wipes to provide perineal and incontinent care if wash cloths were not available and a box of Aloe cleansing pads was provided.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (m) Nursing Staff (2)(A).

8. Based on clinical record review, facility policy and procedures, observation and staff interview for 6 of 24 residents who utilized low air loss mattresses (R#s 66, 90, 92, 99, 109 and 139), the facility failed to implement the necessary care and services to promote healing and/or prevent the development of new pressure ulcers and/or notify the physician when a significant change was noted. The findings include:
   a. Resident # 66's diagnoses included cerebral vascular accident. The quarterly Minimum Data Set dated 12/3/08 identified impaired cognition and extensive assistance for bed mobility. The care plan dated 12/16/08 identified a risk for skin breakdown due to limited mobility with interventions that included utilizing a low air loss mattress. The physician order dated December 2008 directed to provide a low air loss mattress set at " 3 " and to check every shift. Observation on 1/2/09 at 9:30 AM noted the resident in bed with the mattress pump set at the firmest setting (no number calibration was noted on the pump). Interview with the Licensed Practical Nurse # 4 at the time noted she usually checks the mattress pump at 7:00 AM when her shift begins, however, she did not check the pump that morning.
   b. Resident # 90's diagnoses included malnutrition and cerebral vascular accident. The Minimum Data Set assessment dated 12/2/08 identified impaired cognition, extensive

assistance for bed mobility and no pressure ulcers. The care plan dated 12/15/08 identified a risk for skin breakdown with interventions that included utilizing a low air loss mattress. The December 2008 physician orders directed to utilize a low air loss mattress with the setting at " 3 " and to check every shift. A skin integrity report dated 12/30/08 identified a 3.7 centimeter (cm) by 1 cm Stage 2 pressure ulcer on the right upper buttocks and a 2.4 cm by 1 cm Stage 2 pressure ulcer on the left upper buttocks. Observation on 1/2/09 at 9:10 AM identified the resident in bed with the mattress pump set at 4, indicating the mattress was firmer than the ordered setting. Interview with the Assistant Director of Nurses at the time identified it was the responsibility of the charge nurse to check the setting and function of the mattress pump when they come on duty.

c. Resident #92's diagnoses included advanced Alzheimer's disease. A December 2008 physician order directed to utilize a low air loss mattress due to abnormal posture and to set the mattress dial to the resident's weight. The weight record dated December 2008 identified a weight of 102.6 pounds. The quarterly Minimum Data Set assessment dated 11/5/08 identified cognitive impairment and total assistance for bed mobility. The care plan dated 11/18/08 identified a risk for skin breakdown with interventions that included to use a low air loss scoop mattress with the dial set at the resident's weight and to check every shift. Observation on 1/2/09 at 9:10 AM identified the low air loss mattress pump was set at a weight of 170-180 pounds. Interview with the nurse aide at the time who was assigned to care for the resident identified the pump was set by the charge nurse. Interview with the Assistant Director of Nurses on 1/2/09 at 9:15 AM indicated the low air loss mattress was programmed based on the resident ' s weight. The ADNS indicated R #92's weight was 102.6 pounds and the setting on the mattress pump needed to be set at 103. Interview with the charge nurse on 1/2/09 at 9:20 AM identified she checks mattress pumps when treatments are done for the residents and she had not checked the pump that day.

d. Resident #99's diagnoses included Alzheimer's disease and a Stage 4 pressure ulcer. A significant change Minimum Data Set dated 11/15/08 identified impaired cognition, total assistance for bed mobility and a Stage 4 pressure ulcer. The care plan dated 12/4/08 identified a Stage 4 pressure ulcer on the coccyx with interventions that included utilizing a low air loss mattress in bed per the physician's order. The December 2008 physician's order directed to utilize a low air loss mattress set at comfort control setting of "3" and to check the function every shift. Observation on 1/2/09 at 9:30 AM identified the resident in bed with the low air loss mattress set at "5", indicating a firmer setting. Interview with the Assistant Director of Nurses (ADNS) at the time noted the mattress was firm and the setting was adjusted to reflect the physician's order. Interview with the charge nurse on 1/2/09 at 9:30 AM indicated the mattress pumps are usually checked on first rounds when she starts the shift, however, she did not check them on 1/2/09.

e. Resident #109's diagnoses included Alzheimer's disease. A significant change Minimum Data Set assessment dated 11/27/08 identified impaired cognition and extensive assistance for bed mobility. A care plan dated 12/10/08 a risk for skin breakdown due to

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a Stage 2 pressure ulcer on the coccyx with interventions that included to use a low air loss mattress on the bed. The December 2008 Treatment Kardex identified the Stage 2 pressure ulcer on the coccyx healed on 12/16/08. The December 2008 physician's orders directed to utilize a low air loss mattress set at "3" and to check the mattress every shift for function. Observation on 1/2/09 at 9:20 AM identified the low air loss mattress was set at "6" indicating a firmer setting. Interview with the charge nurse at the time indicated she had not yet checked the low air loss mattress pump since the shift began at 7:00 AM.

f. Resident #139's diagnoses included dementia. A quarterly Minimum Data Set a assessment dated 12/3/08 identified impaired cognition and total dependence for bed mobility. The December 2008 physician ' s orders directed to utilize a low air loss mattress set at "3" and to check every shift. Observation on 1/2/09 at 9:20 AM identified the resident in bed with the low air loss mattress pump set at "6" indicating a firmer setting. Interview with the Assistant Director of Nurses oat the time indicated the charge nurses are responsible to check the mattress pump settings and function at the beginning of the shift.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1).

9. Based on clinical record review, observation and staff interview for two of three sampled residents (Resident #'s 21 & R# 42) who were reviewed for contractures, the facility failed to ensure that splints were applied as per the plan of care. The findings include:
   a. Resident #21's diagnosis included multiple sclerosis (MS) and paraplegia. The MDS dated 9/30/08 identified short and long-term memory problems, moderately impaired cognition, the need for extensive assistance with all care and a limitation of range of motion to both arms and hands. Physician orders dated 10/9/08 directed to apply a right elbow and a right hand splint after morning care and remove after six hours. Observation on 12/16/08 at 11:00AM identified the resident was out of bed, without the benefit of the splints. Observation on 12/18/08 at 10:30AM identified the resident was without the benefit of splints. Observation on 12/18/08 at 12:30PM identified the resident was without the benefit of the splints. Interview with the resident on 12/18/08 at 12:20PM identified that staff have not attempted to apply the splints in a long while and that they are left in the closet. Observation at that time identified that two splints were noted to be in the resident's closet. Additionally, the resident stated that she would wear the splints if the staff offered to put them on, although she thinks they may need to be re-adjusted because they start to hurt after wearing them a while. Furthermore, the resident stated that the splints used to be applied during the night and she would occasionally refuse to wear them because they would hurt and keep her awake. Interview with LPN#3 on 12/18/08 at 12:35PM identified that she thought that the

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

splints were to be applied at night and removed in the morning so she had not been applying the splints. Additionally, LPN#3 stated that she had been signing off on the treatment kardex that the splints were on as ordered because she had misread the order. Furthermore, LPN#3 stated the resident use to have the splints applied at night and she was not aware the order had changed. Review of the clinical record with LPN#3 on 12/18/08 at 12:35PM identified that the resident's splint order was changed on 12/28/07 and directed that the splints be applied after morning care and removed after six hours.

b. Resident #42's diagnoses included Alzheimer's dementia and Parkinson's disease. The MDS dated 10/30/08 identified short and long term memory problems, severely impaired cognition, required extensive assistance with dressing and personal hygiene and a limitation in range of motion to both arms and hands. The care plan dated 10/31/08 identified alteration in functional mobility related to contractures with a goal that there would be no increase in contractures. Interventions included to provide passive range of motion and to apply the splints and/or hand roll as per the physician order. A Physician order dated 12/2008 directed to apply a green handroll to the left palm after morning care and remove at bedtime. Observations on 12/1708 at 11:00AM and again at 2:30PM identified the resident was without the benefit of the green hand roll. Additionally, the green hand roll was noted to be on the table next to the resident. Observation on 12/18/08 at 2:20PM identified the resident was without the benefit of the green hand roll. Interview with LPN#1 on 12/18/08 at 2:25PM identified that she worked the day shift on 12/15, 12/16, 12/17 and 12/18/08, and although she did sign the treatment kardex identifying that the hand roll had been applied, LPN#1 stated she did not apply it on those days. Additionally, LPN#1 stated that she did not apply the green hand roll because she thought that therapy was working with the resident and readjusting the splints. Interview with OT#1 on 12/18/08 at 2:30PM identified that although the resident had been followed by therapy, she was not being followed for the green hand roll. Additionally, OT#1 stated that the nurse should have applied the green hand roll as per the physician order.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1).

10. Based on clinical record review, observation and staff interview for two of ten sampled residents (Resident #13 & 19) who were observed during the medication pass, the facility failed to ensure the medication error rate was below 5%. The findings include:
    a. R #3's diagnoses included neuropathic pain. Observation during the medication pass on 12/16/08 at 10:10AM identified LPN #1 open the medication cart and take out a cup containing 4 pills. Interview at that time with LPN #1 stated that the medications were for R #13 and that they were a multivitamin, APAP, Aspirin, and Tramadol. The nurse was observed to administer the medications to the resident. Interview with LPN #1 at

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10:20AM stated that she poured the 4 pills earlier for R #13 but she was sleeping so she put the medications in the cart until now. Review of the medication order sheets dated 11/18/08 directed APAP 1000mg and Tramadol HCL 50mg be administered at 7AM. Interview at that time with LPN #1 stated that the medications of APAP and Tramadol should have been administered at 7AM, two hours and twenty minutes ago, but the Resident was sleeping.

b. R #19's diagnoses included vascular dementia and neuropathy. Physician orders dated 11/11/08 directed Acetaminophen (Tylenol) 1000mg by mouth three times daily at 7AM, 1PM, and 7PM. Observation of the medication pass on 12/17/08 at 9:30AM with LPN#2 identified she administered Acetaminophen 1000mg with the resident's other scheduled 9:00AM medication, two hours late. Interview with LPN#2 at 9:35AM noted that the time of administration for the Acetaminophen was to be changed and was unsure as to the reason the physician ordered it for 7:00AM. The Medication error rate was noted to be 5.45%

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1).

11. Based on clinical record review, observation, review of facility policy and staff interview for seven sampled residents (Residents #19, 30, 127, 132, 156, 173 & 174), reviewed for immunization administration, the facility failed to ensure that immunization policies and procedures were followed. The findings include:
    a. Residents #173 was admitted to the facility on 11/28/08 with diagnoses that included status post stroke. Facility documentation dated 12/1/08 identified the residents responsible person gave permission for the resident to receive the influenza vaccine. Review of the clinical record and facility documentation identified the resident did not receive the influenza vaccination.
    b. Residents #174 was admitted to the facility on 12/2/08 with diagnoses that included dementia. Facility documentation dated 12/3/08 identified the residents responsible person gave permission for the resident to receive the influenza vaccine. Review of the clinical record and facility documentation identified the resident did not receive the influenza vaccination. Interview with RN#3 (ICN) on 12/23/08 at 2:30PM identified that she only works three days per week, (two days for infection control and one day for wounds), and she just didn't get to it. Additionally, RN#3 stated that she didn't get any information from the Unit Managers if new residents had received the immunization in the community.
    c. Review of the clinical records for residents #19, 30, 127, 132, and 156 identified the residents received the influenza vaccination in November 2008. Additionally, review of the clinical record and/or facility documentation failed to show evidence that before offering the influenza immunization, each resident, or the resident's legal representative

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received education regarding the benefits and potential side effects of the immunization. Interview with RN#3 (ICN) on 12/23/08 at 2:30PM identified that although she did mail out information regarding the influenza immunization to the resident's responsible persons, the signed forms were not returned and/or included in the clinical record. Additionally, RN#3 stated that education was not documented in the clinical record for the residents who received the influenza immunization this season.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (g) Reportable Event (7).

12. Based on clinical record review and staff interview for one sampled resident (Resident #30) who was reviewed for a significant medication error, the facility failed to ensure that the error was reported to the state agency as per the public health code Section 19-13-D8t (g) (7), The findings include:
    a. Resident #30 had an assessment dated 9/9/08 that indicated long and short- term memory deficit, resistive to care, required extensive assistance with Activities of Daily Living and abnormal laboratory values within the last ninety days. Review of laboratory results dated 11/17/08 showed R #30's potassium level was 5.8 (normal level: 3.5-5.5). Physician ' s order dated 11/18/08 directed in part, Kayexalate 30 grams to be given by mouth daily for two days. Review of the Medication Administration Record (MAR) dated 11/18/08 at 9 AM noted the medication was not available. A nurse ' s narrative note dated 11/18/08 at 3PM revealed R #30 ' s Potassium was elevated to 5.8,with new noted order.

    Review of a laboratory result dated 11/19/08 indicated potassium level to be 6.19 normal 3.5-5.0). A Physician's order dated 11/19/08 directed Kayexcalate 30 grams to be given by mouth now. Laboratory results dated 11/20/08 showed the potassium level to be 5.1(within normal level). Review of the facility's documentation dated 11/18/08 reflected R# 30 did not receive Kayexalate as ordered by the physician. The documentation also showed that the physician insisted a medication error report to be generated. Review of the generated incident report indentified that the number assigned to the reported had been duplicated. During an interview with the Director of Nursing on 12/22/08 at 11 AM she stated that the report was not sent to the state agency. She also stated that the number assigned to the report was not sequential and it had been duplicated. According to The Department of Public Health Code State of Connecticut, Section 19-13-D8t (g) (7), in part directs each report shall be identified with a number as follows:...and the sequential number of the report during the calendar year.

EXHIBIT A

DATES OF VISIT: commencing on December 16, 2008 and concluding January 2, 2009

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (j) Director of Nurses (2) and/or (k) Nurse Supervisor (1) and/or (o) Medical Records (1).

13. Based on clinical record review and staff interview for eight of fifteen admission sample closed records and/or for one sampled resident observed on oxygen, and for one of two residents reviewed for contractures (R# 11, 31, 42, 72, 84, 144, 155, 167, 169 and 170), the facility failed to ensure the clinical record was complete. The findings include:
    a. Review of the admission sample clinical records on 12/16/08 and 12/17/08 for R # 11, 31, 84, 144, 155, 167, 169, and 170 lacked documentation in the clinical record of recorded weights. Interview and review of the clinical closed records with the Director of Nursing and Assistant Director of Nursing on 12/16/08 and 12/17/08 failed to identify recorded weights in the above clinical records. Additionally, she stated that it is the unit clerk that records weights and at the end of the month prints them. Additionally, the DNS stated that the Medical Records person is responsible to file the printed weights in the residents' chart.
    b. Resident #42's diagnosis included Alzheimer's dementia and Parkinson's disease. The MDS dated 10/30/08 identified short and long term memory problems, severely impaired cognition, required extensive assistance with dressing and personal hygiene and a limitation in range of motion to both arms and hands. The care plan dated 10/31/08 identified alteration in functional mobility related to contractures with a goal that there would be no increase in contractures. Interventions included to provide passive range of motion and to apply the splints and/or hand roll as per the physician order. Physician order dated 12/2008 directed to apply a green handroll to the left palm after morning care and remove at bedtime. Observations on 12/1708 at 11:00AM and again at 2:30PM identified the resident was without the benefit of the green hand roll. Additionally, the green hand roll was noted to be on the table next to the resident. Observation on 12/18/08 at 2:20PM identified the resident was without the benefit of the green hand roll. Interview and review of the treatment kardex with LPN#1 on 12/18/08 at 2:25PM identified that she worked the day shift on 12/15, 12/16, 12/17 and 12/18/08, and although she did sign the treatment kardex identifying that the hand roll had been applied, LPN#1 stated she did not apply it on those days. Additionally, after the interview, LPN#1 subsequently circled her initials on the treatment kardex indicating that the green hand roll had not been applied on 12/18/08.
    c. Resident #72's diagnosis included Alzheimer's dementia and severe COPD. The MDS dated 10/6/08 identified short and long-term memory problems and moderately impaired cognition. The care plan dated 10/10/08 identified the resident was oxygen dependent with a goal that there be no respiratory distress. Interventions included, in part, to observe respiratory status and to provide oxygen as per the physician order. Physician order dated 10/31/08 directed to administer oxygen at two liters via a nasal cannula continuous. Review of the clinical record and interview with LPN#2 on 12/16/08 at

EXHIBIT A

DATES OF VISIT: commencing on December 16, 2008 and concluding January 2, 2009

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

1:10PM identified that although Resident #72 has utilized the Oxymizer for a long while, no physician order or documentation could be found addressing the Oximizer. Additionally, review of the 12/2008 treatment and/or medication administration kardex identified there was no documentation of the Oxymizer having been implemented and/or utilized for Resident #72. LPN#2 stated that the Oximizer converts 0.5 liters of oxygen into 2 liters; therefore, the correct setting for the resident ' s oxygen is 0.5 liters.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D8t (f) Administrator (3).

14. Based on clinical record reviews, facility documentation review and staff interviews, the facility failed to develop and implement appropriate plans of action to correct identified quality of care concerns. The findings include:
    a. Review of 4 of 10 clinical records (Resident #'s 19, 132, 177, and 178) for residents with pressure ulcers, weekly wound monitoring and/or assessments were inaccurate, and/or care plans were not developed and/or care plans were not revised and/or the physician was given inaccurate information regarding the staging of the ulcers and/or the physician orders were not consistently followed. Facility documentation identified the in house facility acquired pressure ulcer percentage in October 2008 was noted to be 0.7%. The November 2008 in house facility acquired pressure ulcer percentage increased to 2.16%. Interview with the Administrator on 1/2/09 at 11:20AM indicated that although wounds are discussed at the morning meetings, there was no documentation of interventions implemented and/or a root cause analysis was not done to address the increase. Additionally, the Administrator stated that a 2.14% facility acquired pressure ulcer percentage was not significantly high and that the residents were discussed on an individual basis. The December 2008 facility acquired pressure ulcer percentage was noted to be 5.0%.